DEPARTMENT	OF HEALTH AND HUMAN SERVICES
CENTERS FOR	MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
	14)	445154	B. WIN	-		4	2012
NAME OF P	ROVIDER OR SUPPLIER	L	<del>- 1</del>		REET ADDRESS, CITY, STATE, ZIP CODE	1 09/10	0/2012
QUALITY	CARE HEALTH CEN	*			32 BADDOUR PARKWAY EBANON, TN 37087	· .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	IĐ PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F	000			
	30410 were comple 10, 2012. No defici d#30140 were cited		F '	1 <del>5</del> 7	F157 483.10(b) (11) Notify of c (Injury/Decline/Room)	hanges	9/20/2012
	consult with the resknown, notify the reor an interested fan accident involving the injury and has the printervention; a signiphysical, mental, or deterioration in heastatus in either life to clinical complication significantly (i.e., a existing form of treatment); or a decitive treatment); or a decitive treatment from the \$483.12(a).  The facility must also and, if known, the more interested family change in room or is specified in \$483.1 resident rights under	ediately inform the resident; ident's physician; and if esident's legal representative mily member when there is an enteresident which results in potential for requiring physician ficant change in the resident's psychosocial status (i.e., a lith, mental, or psychosocial threatening conditions or eas); a need to after treatment entered to discontinue an atment due to adverse to commence a new form of cision to transfer or discharge the facility as specified in esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in ear Federal or State law or cified in paragraph (b)(1) of			1) Upon being made aware by on 9/7/12 that the family was not immediately notified by LPN # DON timely, the Administrator conducted a one on one in-servithe DON and LPN#1 on timely notification as identified in Fed Regulations and Interpretive Graph (Attachment #1)  On 9/7/12 the Administrator co an in-service with all Department and nursing management staff current policy to ensure resident and security as well as making notification of resident's responsant yand state per state regulate (Attachment #2)	ot I or the ice with eral uidelines.  Inducted ont Heads on the it safety timely usible	
	The facility must re	cord and periodically update one number of the resident's					
ABORATOR	VDIRECTOR SOR PROVI	DER/BUPPLIER TEPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

ny deficiency statement ending with an asterist (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days by the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
- j		445154	B. WI	le_		(00/4/	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 09/16	0/2012
QUALITY	CARE HEALTH CEN	ITER		9:	32 BADDOUR PARKWAY EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157	legal representative This REQUIREMEN by: Based on medical investigation, and inotify the resident's allegation of sexual one resident (#5) of The findings include Resident #5 was ac October 13, 2011, v Senile Dementia.  Medical record revious (MDS) dated July 2 was severely impair skills, wandered les "inattentiondiso present, does not fil Medical record revious Note dated July 25, and cooperativeo situation"  Review of facility im signed by Licensed dated August 22, 20 "(Resident #5) po Assistant - CNA #1 who touched me lat (asked) resident, 'V	e or interested family member.  OT is not met as evidenced record review, review of facility interview, the facility failed to responsible party of an abuse in a timely manner for five sampled residents.  ed:  Imitted to the facility on with diagnoses including  ew of a Minimum Data Set 3, 2012, revealed the resident red with decision-making is than daily, and included, rganized thinkingcontinously	F		On 9/10/12 the Administrator and revised the current Abuse clarify the investigation and resection. The Administrator als the Abuse Section of the orien process to include the reportin prevention of Abuse.  (Attachment #3)  2) On 9/14/12 the Administrathe revised Abuse Policy with management staff and DON to other residents have a reported allegation of sexual abuse the responsible party will be notifitimely manner.  (Attachment #4)  Beginning on 9/14/12-9/18/12 reviewed all incident reports for 3 months for timely reporting resident's responsible party. Thundred and eighty six incident were reviewed with no variance on 9/18/12, 9/19/12 & 9/20/12 services were conducted by the ADON with all licensed staff (LPNs) and CNAs on the Abus Any RN, LPN or CNA not atterin-service will not be allowed to work until they have attended service. (Attachment #5)	Policy to porting so revised tation g and tor review all o ensure if l ied in a the DON or the past to the two at reports ses. In-e DON & RNs & e policy, ending the fo return	

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Event ID: OEUU11

Facility ID: TN9505

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PRINTED: 09/12/2012 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
1.		445154	- B. WiN		<u> </u>	,	5
NAME OF O	POVIDED OD CURRUES	443154	<u> </u>			09/1	0/2012
	ROVIDER OR SUPPLIER CARE HEALTH CEN	ITER .	i	9	REET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY EBANON, TN 37087		·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	— х	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157	August 22, 2012, th 5:30 a.m., revealed resident's responsitives allegation. Review of facility in statement) dated August 24, 20 (CNA #1)tried to rate dated August 24, 20 (#5) Date Incident (Incident Reported: 8 (Passistant - CNA #1) raped me last 'noc' revealed, "reported (Passistant - CNA #1) (Director of Nursing Interview with LPN #6:20 p.m., in a conficiality was aware of abuse on August 22 (#2) completed the in allegation. Continue facility failed to notifices in the sident in the siden	ew of nurse's notes dated rough August 23, 2012, at no documentation the ble party was notified of the nof sexual abuse.  Vestigation (an unsigned august 23, 2012, at 8:30 a.m., ith (Resident's) son and at the PM (p.m.) of 8/22/12 fertified Nursing Assistant apper me last night"  Int Abuse Investigation Form 012, revealed, " (Resident Docurred: 8/21/12 Date 8/22/12 Time: 9:00 (p.m.) (at) (Certified Nursing p., stated 'Don't talk to me. You (night)" Continued review d to: Representative Date: 8/23/12 By Whom:	· F1	157	On 10/5/12 a quarterly in-serve be conducted by the DON, AI Staff Educator on Abuse Polici will continue for 12 months.  3) Effective 9/10/12 the DON Administrator will monitor the reporting of the resident's responsive. This will continue inde  4) Beginning 9/18/12, the DON concerning the monitoring out timely notification of resident's responsible party. This will countil substantial compliance is or the QAPI Committee reduction monitoring. The next QI Committee is or the QAPI Committee reduction is scheduled for 9/18/12. Administrator will report to the governing Body concerning the monitoring outcomes on a quarterly monitoring outcomes on a quarterly form.	N and etimely consible finitely.  ON will emittee comes for is continue achieved es mittee it. The ee ese	
F 225 SS=D	C/O: #30410 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/IND	PORT	F 2	25			9/20/2012

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<u> </u>	COT CITTAL DIOMINE	A MEDIOVID OF LAICE?			<del></del>	<u>OMB NO.</u>	<u>0938-0391                                    </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		445154	B, WI	۷G	<del></del>	09/40	) 1/2012
	ROVIDER OR SUPPLIER CARE HEALTH CEN	TER		9:	EET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY EBANON, TN 37087	<u>, _os/(c</u>	112012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	l	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	been found guilty or mistreating resident had a finding entereregistry concerning of residents or mist and report any know court of law against indicate unfitness foother facility staff to or licensing authority. The facility must entered involving mistreatm including injuries of misappropriation of immediately to the stoother officials in a through established State survey and control facility must have a survey and control facility must have a survey and control facility must have a survey and control further pote investigation is in pure the results of all into the administrator representative and with State law (includent, and if the appropriate correct	It employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a san employee, which would be service as a nurse aide or the State nurse aide registry ites.  Sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law I procedures (including to the ertification agency).  In every deficient of the service of the state law of procedures that all alleged ughly investigated, and must ential abuse while the rogress.	F:	225	F 225 483.13(c)(l)(1)(ii)(iii), (4) Investigate/Report/allegations/ls  1) On 9/10/12 the DON compfacility's unsigned statement of 22, 11:00 PM investigation replast names on witness statement signatures and relationship to r  On 9/10/12 the DON conducted on one in-service with LPN # 2 completion of investigative doc full names on documents, dates documents, unsigned document completing all sections of investigation outcomes in the franagement final document.  (Attachment #7)  2) On 9/13/12 the DON and A reviewed all investigations for Aug, September for full names signatures, completion of all set the abuse investigation form.  On 9/14/12 the DON & ADON reviewed and revised the skin assessment form to improve on capturing assessment data, signand date.  (Attachment #8)	leted the f August ort with it, esident.  d a one coments — s on ts, stigative acility  ADON July, ctions on	
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Event ID: OEUU11

Facility ID; TN9505

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		445154	B. Wit			(	
NAME OF F	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 09/10	)/2012
QUALITY	CARE HEALTH CEN	TER ·		93	32 BADDOUR PARKWAY EBANON, TN 37087		:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	IÐ PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	investigation, review report, observation, failed to thoroughly	record review, review of facility v of a police department and interview, the facility investigate an allegation of the resident (#5) of five	, F	225	On 9/18/12, 9/19/12 and 9/20/DON & ADON conducted in-sfor all licensed nursing staff (RLPNs) concerning the revised assessment form including cap signatures, date & time. Any r staff not attending will not be a work until they have attended in-service.	services this & skin sturing nursing allowed to the above	
	October 13, 2011, v Senile Dementia.  Medical record revice (MDS) dated July 2 was severely impairs skills, wandered less "inattentiondisor present, does not fl Medical record revice Note dated July 25, and cooperativeo situation"  Review of facility in Licensed Practical 6, 2012, revealed a unsigned Skin Asseon left side of neck vessels on both right Continued review rebluish-purple quarte sides of both knees (old) (just below left purple dime size (o	Imitted to the facility on with diagnoses including with diagnoses including aw of a Minimum Data Set 3, 2012, revealed the resident red with decision-making is than daily, and included, rganized thinkingcontinously uctuate"  I we of a Psychiatric Progress 2012, revealed, "pleasant riented to person, place, and westigation provided by Nurse (LPN) #2 on September in undated, untimed, and ressment and included, "Red from chin to shoulderblood in and left top thigh"  I evealed, "1. Discoloration er size 1 inch long (old)(outer b) 2. Red circle quarter size telbow) 3. Discoloration dark and (left elbow) 4. Discoloration size (old) (left hand)6.			<ul> <li>3) On 9/12/12 the Administra monitoring each investigative Abuse Investigations for signal names on all documents, compall sections of the investigative including any police investigative including any police investigative information in the final outcomes tatement. This monitoring we continue indefinitely by the Administrator.</li> <li>4) On 9/18/12, the Administrator begin reporting quarterly to the Committee concerning the more outcomes for completion of investigative forms relative to signatures, full names, complete all sections. This will continue substantial compliance is achieved the QI Committee reduces monomorphisms. The next QI Committee meeting scheduled for 9/18/12. The Administrator will report to the governing Body concerning the monitoring outcomes on a quantasis beginning 9/18/12.</li> <li>(Attachment #6)</li> </ul>	file of attures, full pletion of e forms tive me rill attor will e QI nitoring tions of e until eved or nitoring. eg is	

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Event ID; OEUU11

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445154	B. WII	۷G _		09/10	C 0/2012
	ROVIDER OR SUPPLIER CARE HEALTH CEN	ITER		9	REET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY -EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTT CROSS-REFERENCED TO THE APPIRED DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	discoloration dark p left knee) 7. Discolo hand)" Review of facility in	ge 5 purple quarter size (old) (back pration (old) dime sized (right vestigation (an unsigned ugust 22, 2012, at 10:00 p.m.,	F	225			
	revealed, "at appr witnessed (resident calmAt approxima	roximately 6:15 (p.m.) I i)visiting withsonbehavior ately 9:45 (p.m.) I spoke with (something to eat)"					
D.	signed by Licensed dated August 22, 20 "(Resident #5) po Assistant - CNA #1] who touched me last resident, 'What's wi	vestigation (a statement Practical Nurse - LPN) #1 D12, at 10:10 p.m., revealed, inted at Certified Nursing )and said, (CNA #1) the one st nightCNA (#1) ask rongand (resident) stated, u tried to rape me last night"					
	"Interview with Resi				·		
	statement) dated Al revealed, "Spoke w informed him that in (resident)said, 'Co CNA #1)tried to ra	vestigation (an unsigned ugust 23, 2012, at 8:30 a.m., ith (Resident's) son and the PM (p.m.) of 8/22/12 ertified Nursing Assistant - ape me last nighttold him we il investigation and would also				·	
	dated August 24, 26	nt Abuse Investigation Form 012, revealed, "(Resident Occurred: 8/21/12Date					

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Event ID: 0EUU11

Facility ID; TN9505

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ILTIPLE CONST	TRUCTION	1	(X3) DATE SU COMPLE	
<b>**</b>		445154	B. WING			- [	C	_
NAME OF P	ROVIDER OR SUPPLIER	443134		·			09/10	0/2012
	CARE HEALTH CEN	TER		932 BADDO	ESS, CITY, STATE, ZIP ( DUR PARKWAY I, TN 37087	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E)	PROVIDER'S PLAN OF C ACH CORRECTIVE ACTIV SS-REFERENCED TO TH DEFICIENCY	ON SHOU HE APPRO	LDBE	(X5) COMPLETION DATE
F 225	(at) (Certified Nursin #1)stated 'Don't ta 'noc' (night)" Contitudings indicate NO, please explain) of the form was blan Review of a facility in August 28, 2012, redecided that a full in unnecessary"  Review of facility invidocumentation by a investigation.  Observation and int September 6, 2012, development room, tape dated August 2 through 10:00 p.m. alleged to have occurevealed LPN #3 hat tape after CNA #1's interview revealed L security tapes for the 2012 but only during duty.  Observation and int September 6, 2012, room, revealed no was unable to identitidisoriented to time, Interview with LPN #	and Assistant - CNA alk to me. You raped me last inued review revealed, "Did that abuse occurred? No (if" The "explanation" section ink.  Investigation report dated vealed, "Officer (police) investigation and rape kit was restigation revealed no police officer regarding the  erview with LPN #3 on at 6:55 p.m., in a staff revealed a security camera 12, 2012, from 2:00 p.m. (the night after the abuse was urred). Continued interview id not reviewed the security shift ended. Continued PN #3 had reviewed the eweek including August 22, if the times CNA #1 was on erview with the resident on at 6:50 p.m., in the resident is isible bruises and the resident if (resident's) last name and place, and situation.	F 2:	25				
		erence room, revealed LPN						

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Event ID: OEUU11

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STATEMENT AND PLAN (	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
*		445154	B. WING_		1	>
NAME OF P	ROVIDER OR SUPPLIER	170107		TELT ADDRESS OFFI STATE TO SOLE	09/10	0/2012
QUALIT	CARE HEALTH CEN		9	REET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY .EBANON, TN 37087		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÐ PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	#2 interviewed the r Continued interview the facility's investig allegation and witne last names, signatu the witnesses to the confirmed the facilit	resident on August 23, 2012. If revealed LPN #2 completed lation regarding the resident's less statements did not include res, and/or the relationship of le resident. Continued interview by failed to thoroughly t #5's allegation of sexual	F 225			
F 226 SS≓D	The facility must de policies and proced mistreatment, negle	ETC POLICIES velop and implement written	F 226	F 226 483.13(c) Develop/Im abuse/Neglect, etc Policies  1) On 9/7/12 the Administra conducted an in-service with a Department management staff reporting of abuse, investigational completing investigative (Attachment #2)	ntor all f on ng abuse,	91/20/2012
	by: Based on review of review, review of factorice department in facility failed to imple	facility policy, medical record cility investigation, review of a aport, and interview, the ement the abuse policy for five sampled residents.		On 9/10/12 the Administrator and revised the current Abuse clarify the reporting and invessection. The Administrator al the Abuse Section of the orier process to include the reporting prevention of Abuse.  (Attachment #3)	Policy to stigation so revised station	
	Neglect Prohibition revealed, "All alleg mistreatment, negle immediately to the a to other officials in a	licy titled "(facility) Abuse and Policy dated August 10, 2012, ged violations involving ct, abusewill be reported administrator of the facility and accordance with state law proceduresSexual abuse		On 9/12/12 the DON identified nurse who conducted the Skin Assessment that was undated, and unsigned and obtained all information including the sout findings for that skin assessment.	untimed, rce of the	

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Event ID: OEUU11

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9/24/2012

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEPLAY OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445154	B. WIN			C	· .
NAME OF P	ROVIDER OR SUPPLIER			e T D	EET ADDRESS, CITY, STATE, ZIP CODE	09/10	0/2012
QUALITY	CARE HEALTH CEN	TER		93	22 BADDOUR PARKWAY EBANON, TN 37087	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	sexual coercion, or unknown source is meets both of the for source of the injury person or the source explained by the resinjuries observed at timeThe facility wishould report their leallegationsThe Acreport all allegations occurrences of missisthe state agency and designated by state.  Resident #5 was according to the state agency and designated by state.  Resident #5 was according to the state agency and signated by according to the state agency and signated by state.  Medical record review (MDS) dated July 25 was severely impair skills, wandered les "inattentiondisor present, does not fill Medical record review Note dated July 25, and cooperativeor situation"  Review of facility in signed by Licensed dated August 22, 20 "(Resident #5) po Assistant - CNA #1"	nited to sexual harassment, sexual assaultInjury of defined as an injury that ollowing conditions: a. The was not observed by any e of the injury could not be sident; andthe number of one particular point in ill train employeesHow staff knowledge related to iministrator or designee will as and substantiated treatment, neglect, abuseto d law enforcement officials as law"  Imitted to the facility on with diagnoses including  ew of a Minimum Data Set 3, 2012, revealed the resident red with decision-making s than daily, and included, ganized thinkingcontinously	F2	226	2) On 9/14/12, 9/15/12, & 9/17 DON & ADON conducted survother residents for accurately conskin assessments and any positifindings not reported per incide reporting process.  On 9/14/12 the DON & ADON reviewed and revised the skin assessment form to improve on capturing assessment data, signal and date.  (Attachment #8)  On 9/14/12 the Administrator rethe other allegation of abuse for accuracy and completeness of the "Resident Abuse Investigative In (Attachment #9)  On 9/18/12, 9/19/12 and 9/20/12 DON & ADON conducted in-sefor all licensed nursing staff (RI LPNs) concerning the revised sassessment form including capt signatures, date & time. Any mataff not attending will not be a work until they have attended the in-service. (Attachment #5)	eys of ompleted ve nt atures, eviewed to be Form".	

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Event ID: OEUU11

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
)		445454	B. WING		С
·		445154	D. Millo	· · · · · · · · · · · · · · · · · · ·	09/10/2012
QUALITY	ROVIDER OR SUPPLIER  CARE HEALTH CEN		9	REET ADDRESS, CITY, STATE, ZIP CODE 132 BADDOUR PARKWAY LEBANON, TN 37087	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION
F 226	(asked) resident, 'W stated, 'don't talk to night'! went to cha (asked)what to do nurse) statedwas supervisor probably Review of facility inv Licensed Practical 16, 2012, revealed and unsigned Skin Asseon left side of neck vessels on both right Continued review rebluish-purple quartersides of both knees (old) (just below left purple dime size (olbluish-purple d	what's wrongand (resident) me you tried to rape me last arge nurse and ask with information and (charge unsure, but to notify "" westigation provided by Nurse (LPN) #2 on September of undated, untimed, and essment and included, "Red from chin to shoulderblood at and left top thigh" evealed, "1. Discoloration er size 1 inch long (old)(outer 2. Red circle quarter size elbow) 3. Discoloration dark d) (left elbow) 4. Discoloration size (old) (left hand)6. urple quarter size (old) (back tration (old) dime sized (right	F 226	3) On 9/18/12 the DON, ADO Unit Managers began monitoring completion of the skin assessment accuracy, signatures, and full mall assessments. This monitoring continue for at least 6 months at the QI committee will determine frequency of monitoring at the months. (Attachment #10)  On 9/12/12 the Administrator be monitor each investigative file. Investigations for signatures, for all documents, completion of sections of the investigative for monitoring will continue indefit the Administrator.  4) Beginning 9/18/12, the DON report quarterly to the QI Committee completion of Skin Assessment and completion of Skin Assessment and completion of incident report any positive findings. This will continue until substantial completed or the QAPI Committee reduces monitoring. The next Q Committee meeting is scheduled 9/18/12. The Administrator will to the governing Body concerning monitoring outcomes on a quart basis beginning 9/18/12. (Attachment #6)	ng the ent for ames on ng will and then he end of 6 he end of 6 he end of Abuse all names of all ms. This nitely by  I will nattee omes for Form out for he end of all for l report ng these

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Adminwhlan

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
18			A. BUILDIN	<u> </u>	С	ŀ
- 1		445154	B. WING_	· · · · · · · · · · · · · · · · · · ·	09/10/20	012
	ROVIDER OR SUPPLIER  CARE HEALTH CEN	ITER ·	9	REET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE CO	(X5) MPLETION DATE
F 226	Continued review of findingsreported to Date: 8/23/12Law 8/23/12Administration of a local probabilistic Review of a local probabilistic Report date call was received a "Personal Details - DON)caller is a one of the patients 10/55 B (rape)."  Telehpone interview September 10, 201	on of the form was blank. evealed, "Results of to: Representative (Sponsor) of Enforcement Agencies Date: ator Date: 8/22/12"  colice department Incident of August 23, 2012, revealed a t 9:37:02 (a.m.) and included, cCaller(Director of Nursing MGR (manager) and advised is stating someone attempted  of with the Administrator on 2, at 12:35 p.m., confirmed implement the abuse policy for	F 226			

.. A parallo

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